



CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION
BOARD OF MEDICAL LICENSURE AND DISCIPLINE

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV

APPLICATION FOR PHYSICIAN TRAINING LICENSURE RESIDENTS, INTERNS, FELLOWS, HOUSE PHYSICIANS

INSTRUCTION SHEET

When to Apply

File this application when a physician is employed in an ACGME-approved ***institution located in Delaware*** and is:

- a Resident, Intern or Fellow registered in a training program outside of Delaware who will rotate through a program in Delaware for over one month, or
- employed as a House Physician

For more information, see Section 5.2 of the Board's [Rules and Regulations](#) available online at www.dpr.delaware.gov.

Requirements for All Applicants

- ☐ Submit completed, signed and notarized [application form](#).
 - Both applicant and Director of Training Program/Supervising Physician must sign the application in front of the notary.
- ☐ Enclose the [processing fee](#) by check or money order made payable to "State of Delaware."
- ☐ If you answer "yes" to Questions 16 - 29 in the DISCLOSURES section, you must fully explain your answer. It is suggested that you use the [Physician Self-Report](#) form for this purpose. However, if the *Physician Self-Report* does not fully cover your situation, you may submit a signed, notarized statement in lieu of or in addition the *Physician Self-Report*.
- ☐ Complete the *Criminal History Record Check Authorization* form to request state and federal criminal background checks. Follow the instructions on the form to arrange to be fingerprinted.
 - You must meet this requirement *even if* you recently had a criminal background check done for some other reason.
- ☐ If you have never been issued a U.S. Social Security Number (SSN), submit a [Request for Exemption from Social Security Number Requirement](#).
 - *The Privacy Act of 1974, Section 7, requires the following information to be given to all applicants:* Applicants for any Delaware professional or occupational license, permit, registration or certificate (other than Gaming permits) are required to provide a U.S. SSN (29 Del. C. §8735(m)). The Division of Professional Regulation uses the SSN primarily to verify identity and safeguard personal information. It may also be used to enforce child support obligation (13 Del. C. §2216) and for other lawful purposes.

Additional Requirements for Fellows and House Physicians

If you are employed as a Fellow or House Physician, the following additional requirements apply.

- ☐ Submit an 8 1/2" X 11" copy of your Postgraduate Education Training Certificate(s).
- ☐ A personal interview with a member of the Board is required. When your application has been reviewed, the Board office will notify you whom to contact to schedule your interview.



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**APPLICATION FOR PHYSICIAN TRAINING LICENSURE
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IDENTIFYING AND CONTACT INFORMATION

1. Full Name: _____
Last First Middle
2. Other Names Used: _____
(Include maiden, prior married, alternate spellings)
3. Date of Birth (month/day/year): _____ Gender: Male ☐ Female ☐
4. Have you been issued a U.S. Social Security Number? Yes ☐ No ☐
 - a. If yes, enter your SSN: _____
 - b. If no, you must file a [Request for Exemption from Social Security Number Requirement](#).
5. Personal Address: _____

City State Zip
6. Phone: _____ Email: _____
Home Work

INSTITUTION INFORMATION

7. Enter this information about the institution **in Delaware** where you will be employed/trained:
Name: _____ Department: _____
Mailing Address: _____
This is the address to which all correspondence, including your ACGME Training license, must be sent.

City State Zip
Phone: _____
8. Start Date of Employment/Training (month/day/year): _____
9. Type of Employment/Training (check one):
☐ Intern ☐ Resident ☐ Fellow ☐ House Physician
10. Do you understand that you must limit yourself solely to practice within the hospital or to medical duties outside the hospital that are assigned to you as part of your internship or resident training program? Yes ☐ No ☐

MEDICAL EDUCATION

11. Enter this information about your medical school:

Name: _____ Graduation Date: _____

Location Address: _____

City

State

Zip

If you were not a U.S. citizen when you enrolled in a medical school outside the U.S., submit 8 1/2" X 11" copy of your ECFMG certificate.

12. If you are employed as a Fellow or House Physician, enter complete information about your post-graduate training. If you are employed as an Intern or Resident, skip to Question 13.

HOSPITAL/INSTITUTION	LOCATION	DATES OF TRAINING	SPECIALTY

If you are employed as a Fellow or House Physician, submit an 8 1/2" X 11" copy of your Postgraduate Education Training Certificate(s).

EXAMINATION AND LICENSURE HISTORY

13. Have you ever taken any of these examinations administered by the USMLE, FLEX, National Board, or State Boards? Yes ☐ No ☐ If yes, provide the following information:

EXAM	LOCATION	DATE

14. Have you ever failed a licensing exam? Yes ☐ No ☐ If yes, provide details: _____

15. Have you ever held a medical license issued by a state or U.S. territory? Yes ☐ No ☐ If yes, list *each* state or U.S. territory where you now hold, or have ever held, a medical license, including training licenses.

STATE/TERRITORY	LICENSE NUMBER	ISSUE DATE	EXPIRATION DATE

DISCLOSURES

If you answer "yes" to Questions 16 - 29 in this section, you must fully explain your answer. It is suggested that you use the *Physician Self-Report* form for this purpose. However, if the *Physician Self-Report* does not fully cover your situation, you may submit a signed, notarized statement in lieu of or in addition the *Physician Self-Report*. The statement should specify the state where the incident occurred, the issues involved and any further information you wish to provide.

16. Have you ever been convicted of or entered a plea of guilty or *nolo contendere* (no contest) to any felony, misdemeanor or any other criminal offense in any jurisdiction, including any offense for which you have received a pardon? Yes ☐ No ☐

Arrange for the Board office to receive state and federal criminal background checks.

17. Have you ever been convicted of violating the Medical or Osteopathic Practice Act of another state? Yes ☐ No ☐
18. Have you ever engaged in the practice of medicine or osteopathy without a license? Yes ☐ No ☐
19. Have you ever been refused a narcotic license or had such license modified, suspended, canceled, or prescribed narcotic drugs unlawfully? Yes ☐ No ☐
20. Have you ever willfully violated the confidence of a patient? Yes ☐ No ☐
21. Have you ever been convicted of fraud? Yes ☐ No ☐
22. Have you ever had a medical or osteopathic license denied, revoked, suspended, or limited or placed under probation? Yes ☐ No ☐
23. Have you ever had any action taken against you by the Narcotics Bureau of the Treasury Department, or the Drug Enforcement Agency of the Department of Justice or a State's Narcotic Agency in this country or any other country? Yes ☐ No ☐
24. Have you ever had a disciplinary action taken against you by a Medical or Osteopathic Society? Yes ☐ No ☐
25. Have your hospital privileges ever changed as a result of a disciplinary action taken by a hospital? Yes ☐ No ☐
26. Has a settlement ever been made or a verdict rendered against you in a malpractice action? Yes ☐ No ☐
27. Are any charges pending against you or are you under investigation regarding a felony or misdemeanor or unprofessional conduct, or professional misconduct, or malpractice? Yes ☐ No ☐
28. Are you now, or have you ever been dependent upon the use of alcohol, stimulants, or habit-forming drugs or been treated or disciplined for their use? Yes ☐ No ☐
29. Have you had either a mental or physical illness which interfered with your practice for over a month? Yes ☐ No ☐
30. Are you physically and mentally capable of engaging in the practice of medicine according to generally accepted standards, and would you submit to such an examination as the Board may deem necessary to determine your capability? Yes ☐ No ☐

If this application requires Board review, the Board office must receive all of these items no later than 4:30 PM ten full working days before the Board's meeting date:

- Completed, signed and notarized application form
- Fee payment
- All required supporting documentation.

Applications that are not complete within six (6) months of filing may be considered abandoned and discarded.

Please note: When your application is complete, please allow 4-8 weeks to receive your license. A complete application is one that includes all required documentation and correct payment.

APPLICATIONS THAT ARE INCOMPLETE, UNSIGNED, NOT NOTARIZED OR NOT ACCOMPANIED BY THE REQUIRED PROCESSING FEE WILL BE REJECTED.

AFFIDAVIT OF APPLICANT

I swear that I am the person who executed this application, that the statements contained on this application are true in every respect, that I have not suppressed or withheld information that might affect this application, that I will abide by the laws and the ethical standards of this profession, and that I have read and understand this statement.

I affirm that I will limit my practice of medicine in Delaware to the hospital where I am employed or to medical duties outside of the hospital which may be assigned to me as part of my internship or residency training program, provided that such outside duties are performed under the supervision of a regularly licensed physician.

I further affirm that I understand that this license will expire on the day my employment with this institution ends. I agree to notify the Board office no later than three days following the end of the employment relationship.

Signature of Applicant: _____ **Date:** _____

VERIFICATION OF DIRECTOR OF TRAINING PROGRAM

I verify that the above-named Resident/Intern/Fellow/House Physician will be employed or participating in a training program at _____ beginning _____
Name Of Institution month/day/year
and that he/she will be under the supervision of a fully licensed physician in the State of Delaware. I further certify that the credentials of the Resident/Intern/Fellow/House Physician have been reviewed and approved. I understand that this license will expire on the day the applicant's employment with this institution ends, and I agree to notify the Board office no later than three days following the end of the employment relationship.

Printed First and Last Name of the Director of the Training Program

Signature of Director: _____ Date: _____

Delaware Physician License Number: _____

STATEMENT OF SUPERVISING PHYSICIAN

I accept responsibility for the applicant's practice of medicine and surgery in this institution.

Printed First and Last Name of Supervising Physician

Signature of Supervising Physician: _____ Date: _____

Delaware Physician License Number: _____

NOTARY PUBLIC

State of _____, County of _____

Sworn and subscribed before me this _____ day of _____ 2_____.

Notary Public: _____

My Commission expires: _____

SEAL

Instructions for Requesting a Criminal Background Check

Both state and federal criminal background checks are required.

Locations

Kent County – Primary Facility

State Bureau of Identification
Blue Hen Mall & Corporate Center
655 Bay Rd. Suite 1B
Dover, DE 19901

Walk-ins accepted: Mon 9 am – 7 pm, Tue - Fri 9 am – 3 pm

Customer Service: (302) 739-2134

New Castle County - Satellite Facility

State Police Troop Two
100 LaGrange Ave
Newark, DE 19702
(Between Rts. 72 and 896 on Rt. 40)

By appointment only

Scheduling: (302) 739-2528 (local)

(800) 464-4357 (toll free)

Sussex County – Satellite Facility

Delaware State Police Troop Four
South DuPont Hwy & Shortley Rd. Georgetown DE
19947

(Across from DelDOT & the State Service Ctr.)

By appointment only

Scheduling: (302) 739-2528 (local)

(800) 464-4357 (toll free)

Applicants Residing in Delaware

1. If you are using the New Castle or Sussex Counties locations, call **(800) 464-HELP (4357)** to schedule an appointment. No appointments are needed at the Kent County location.
2. Take the completed *Authorization for Release of Information* form to one of the offices listed above with the fee of \$69.00, to cover both the State and Federal criminal checks. Money orders and credit cards other than American Express are accepted at all locations. New Castle and Kent Counties accept cash; Sussex County does not accept cash. *Personal checks are not accepted in any county.* As fees are subject to change, contact the agency where you plan to submit your forms for current fees.

Out-of-State Applicants

1. You can be fingerprinted by your local police agency. All types of fingerprint cards are accepted. If your local police agency cannot provide a fingerprint card, call **(302) 739-2134** to request a fingerprint card.
2. Your *Authorization for Release of Information* form and fingerprint card must be complete. If identifying information is missing (such as name, date of birth, race, sex, etc.), your form will be returned. Send the *Authorization* form, fingerprint card, and certified check or money order (*personal checks are not accepted*) for \$69.00 made payable to "Delaware State Police" to:

Delaware State Police
State Bureau of Identification (SBI)
PO Box 430
Dover, DE 19903-0430

⇒ **ALLOW FOUR WEEKS FOR RECEIPT OF RESULTS.**

DO NOT SEND THE FORM OR FEE TO THE BOARD OFFICE



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AUTHORIZATION FOR RELEASE OF INFORMATION

CRIMINAL HISTORY RECORD CHECK FOR PROFESSIONAL LICENSURE APPLICANTS

PLEASE PRINT OR TYPE ALL INFORMATION IN BLACK INK.

CHECK TYPE OF LICENSURE FOR WHICH APPLYING:

- | | |
|--|---|
| <input type="checkbox"/> Adult Entertainment | <input type="checkbox"/> Nursing Home Administrator |
| <input type="checkbox"/> Deadly Weapons Dealer | <input type="checkbox"/> Pharmacy |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Texas Hold'em Dealer |
| <input type="checkbox"/> Medical | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Nursing | |

ENTER FULL CURRENT NAME:

_____	_____	_____	_____
Last Name	First Name	Middle Initial	Suffix (e.g., Jr., Sr.)

ENTER ALL OTHER NAMES USED IN THE PAST (including, but not limited to, maiden name, former married names, alternative spellings):

1. _____
2. _____
3. _____
4. _____

AUTHORIZATION TO RELEASE INFORMATION

As an applicant, I authorize release of any and all information that you have concerning me, including **CRIMINAL HISTORY RECORD INFORMATION** and other information of a confidential or privileged nature. I hereby release you, your organization, the State of Delaware and others from any liability or damage which may result from furnishing this information:

SIGNATURE OF PERSON PRINTED: _____ **Date:** _____

Phone: Home _____ Work: _____

MAIL THE RESULTS OF MY CRIMINAL HISTORY REQUEST TO:

Division of Professional Regulations
861 Silver Lake Boulevard, Suite 203
Dover DE 19904
SLC D420A

USE OF CRIMINAL HISTORY RECORD INFORMATION IS RESTRICTED BY LAW AND SHALL BE LIMITED TO THE PURPOSE FOR WHICH IT WAS GIVEN. MISUSE CONSTITUTES A CRIMINAL VIOLATION.